

NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS
Application for Privileges
N.J.A.C. 13:35-4A.12

Anesthesiology
CONSCIOUS SEDATION

PRIVILEGE CRITERIA

Conscious Sedation:

1. Attestation (Attachment 1 - in attestation format provided)

I am demonstrating clinical experience by attesting, in Attachment 1, to the number of procedures for which I provided conscious sedation, in the last two years with acceptable results for patients of all age groups, except as specifically excluded from practice, **plus**

2. Training (Attachment 2)

I am providing, as Attachment 2, documentary evidence of **one** of the following:

Current certification in:

(1) Anesthesiology granted by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology or any other certification entity that is demonstrated by the applicant to have standards of comparable rigor, **OR**

(2) Critical Care Medicine or Emergency Medicine by a specialty board or other certifying entity recognized by the American Board of Medical Specialties ("ABMS") or the American Osteopathic Association ("AOA" or certification in these areas by any other certification entity that is demonstrated by the applicant to have standards of comparable rigor, **OR**

(3) Advanced Cardiac Life Support training for treating adult patients; Pediatric Advanced Life Support training for treating children **and either:**

- (a) successful completion of an educational home study program, with a test of basic knowledge, approved by the Board; **OR**
- (b) a course in conscious sedation offered by a licensed hospital or for continuing medical education credits; and,

3. Record Review/Clinical Observation (Attachment 3 - in format provided)

References - Names, addresses and specialty, residency or observation only

I am providing, as Attachment 3, the names, addresses and specialty of three plenary licensed physicians who will directly submit references addressing my current

Licensee Name: _____ License Number: _____

competence based on their personal knowledge obtained either during a residency training completed during the two years preceding the date of this application or through personal observation during the two years preceding the date of this application.

4. Log of procedures (Attachment 4B Conscious Sedation - in format provided)

I am providing, as Attachment 4B, a log listing:

(1) only patients who experienced complications relating to my provision of conscious sedation in an office setting or licensed ambulatory care facility setting, during the two years preceding the date of the application, and

(2) the resulting outcomes of such complications.

The log includes a patient number, the type of anesthesia service provided, the surgery or special procedure performed and the date(s) of the service. Patient names and other personal identifiers are redacted.

I am maintaining in my office a list or other means to identify the patient, based on the number included in the log.

As part of the application for privileges process, from the log I am providing, at least 5 cases, with personal identifiers redacted, that are representative of complications in my provision of conscious sedation will be selected and I will be asked to provide for each, patient records, with patient personal identifiers redacted, along with a case summary form, with patient personal identifiers redacted, for each submitted case.

DELINEATION OF PRIVILEGES

I have checked the column on the left of those agents listed below to indicate those agents I intend to administer in the office setting.

Requested Privileges

_____	Diazepam
_____	Versed
_____	Barbiturates
_____	Meperidine
_____	Ketamine
_____	Other

Any additional agent(s) for which I am requesting privileges are specified below. I have provided supporting documentation concerning training and clinical experience with the requested conscious sedation agents on a separate Anesthesia Conscious Sedation Addendum page.

Licensee Name: _____ License Number: _____

I do not / do (circle one) have privileges to perform Conscious Sedation at a licensed health care facility(ies), such as licensed ambulatory care facilities _

The facility(ies) is (are) ____

Approximate number of conscious sedation cases I performed over the last year is: _____

My current life support training is:

_____ BLS Certification - Expiration date _____
_____ Advanced Life Support - Expiration date _____
_____ Pediatric Advanced Life Support - Expiration date _____

I certify that my attestation of the number of procedures and any materials provided incident to this form (i.e. "supporting documentation") are true and accurate. I am aware that if any of the foregoing statements made by me or if the materials submitted by me are willfully false, I am subject to punishment.

Signature and printed name of Applicant

Date

Below this line for Administration Use Only

Application Tracking Record:

Initial Receipt Date of Application	_____
Transmittal Date to Outsourcing Entity	_____
Supplemental Information Requested	_____
Supplemental Information Received	_____
Outsourcing Entity Recommendation	_____
Outsourcing Entity Reviewer	_____
Board Committee Review Date	_____
Board Disposition Date	_____

Licensee Name: _____ License Number: _____